

May 2010

**Modernizing Primary Care Graduate Medical Education
to Produce a Healthy America
A Pilot Project**

RECOMMENDATION:

Congress should support legislation to implement a budget-neutral pilot project to test new models of the use of Medicare Graduate Medical Education Funding (GME) for the training of primary care physicians.

Description of the Pilot

This project would revise the way GME payments are made to support production of a robust primary care workforce. Over time the U.S. should have a physician workforce that is at least 45 percent primary care and uniquely trained to meet the needs of current and future patients. Such a pilot is consistent with the recommendations of the Medicare Payment Advisory Commission (MedPAC) which states: "Reforming medical education will be a key component to transforming the nation's health care delivery system from one that historically has focused on care for acute illness to one that values patient-centered care, quality improvement, and resource conservation." (MedPAC, June 2009) To accomplish this, the pilot would:

- Support primary care training in all sites where care is delivered
- Structure GME payments for primary care residencies to directly fund an entity where education is the primary mission
- Increase payments for primary care training to support added costs of training in non-hospital settings, as well as to offer incentives to medical students who choose a primary care career
- Provide incentives for training in rural and underserved areas

At least four models of governance have been identified currently extant within family medicine. Others may also exist. The pilot should test at least two situations of each of the models identified. These are:

- (1) A community-based independent corporate entity collaborating with two or more hospitals in operating one or more primary care graduate medical education programs. (e.g., Siouxland Medical Education Foundation/Sioux City, IA, Family Medicine Residency of Idaho/Boise, ID, Montana Family Medicine Residency/Billings, MT)
- (2) A medical education entity established by two or more hospitals to develop and operate one or more primary care graduate medical education programs. The hospitals may be the sole corporate members, but the governing board has community representatives. (e.g., Cedar Rapids, IA)
- (3) A hospital subsidiary or independent corporation operating one or more primary care graduate medical education programs for the hospital with community participation in the governance of the organization. (e.g., Augusta, ME)
- (4) A medical education entity, that is independent of any hospital but collaborates with a hospital in operating one or more graduate medical education programs. The medical education entity may include a university or school of medicine. (e.g., Madisonville, KY, Salina, KS, Lawrence, Massachusetts, Wayne State University, Rochester, MI, and Southern Illinois University, Quincy, IL)

Meeting the Primary Care Need

The current lack of a sufficiently strong primary care physician workforce has hurt our country and our patients. It results in increased costs and lower health outcomes. With the passage of the Patient Protection and Affordable Care Act (PPACA) and the inclusion of an additional almost 30 million new covered lives, GME must now ensure a workforce able to meet the needs of our nation's population at large. Both numbers and proportion of primary care physicians need to be substantially increased. Funding of training has a profound impact on the development of a primary care workforce. Currently, Medicare GME does not foster the production of high quality and high numbers of primary care physicians – in fact, it hinders these twin goals. This is inconsistent with the mission of GME which had its genesis in Medicare for the purpose of ensuring a sufficient workforce to care for the Medicare population.

Steps to Modernization

Residency experience in nonhospital and community-based settings is important because most of the medical conditions that practicing physicians confront should be managed in nonhospital settings. (MedPAC, June 2009). Changing the funding stream, emphasizing training consistent with contemporary practice, and enhancing accountability for the product are all key steps toward modernization of the funding of primary care GME. The current GME payment system is hospital-oriented, reflecting the inpatient hospital model of care which was the practice norm when the program was established forty years ago but which is no longer the case with contemporary primary care practice. The outdated GME payment formula does not substantively compensate for the costs of training in nonhospital settings, where most primary care patient services are delivered and where most training should occur. It fails to foster innovation or enhanced quality of the graduate, and it lacks accountability for the type of product produced. Current national needs require changes in what training is paid for, and what product is produced. Financial incentives inherent in current Medicare law and regulations strongly encourage teaching hospitals to confine their resident's learning experiences to within the hospital (MedPAC, June 2009.) This is still the case, even with some positive changes regarding counting resident time in the community that were included as part of PPACA.

Accountability for the “Product”

Current allocation of GME funds bears no relation to training nor to the physician that is produced. It is solely based on estimates of the “extra costs” a hospital may incur from having residents train in that setting. In fact, there is currently no requirement that the GME funds be used for education. A number of reports and articles have expressed concern that our health professionals are not learning certain skills necessary to work optimally in delivery systems that provide the kinds of care that will best serve the public's needs.” (MedPAC, June 2009) Directing the payment to the primary care training programs that, in concert with accrediting bodies, are responsible for the residents' education and assuring the program meets community needs, will achieve increased accountability while more efficiently funding the program to pay the costs and meet the requirements associated with primary care training.

Family medicine supports more consistency in the training of graduates. Such training should be predicated on competency-based curricula as well as a core set of skills, processes and knowledge. Training should: 1) be consistent with community needs, 2) support innovation to encourage enhanced quality and efficiency, 3) provide graduates with the ability to build and manage clinical practices – including ones delivering care in new models such as the patient-centered medical home, and 4) be able to adjust to meet current and future patient needs and medical knowledge.